FROM THE GMSC

Negotiators authorised to discuss white paper with ministers

The General Medical Services Committee has authorised its negotiators to start discussions with the Department of Health on the negotiable aspects of the white paper on primary health care. A package will be brought back to the committee for consideration and Dr Michael Wilson told members that he thought that detailed negotiations would take about a year.

A standing committee of the House of Commons is already discussing the Health and Medicines Bill and has met twice. The government aims at having the bill on the statute book by the summer of 1988.

Committee members gave the proposals a cautious reception but criticised in particular the lack of real extra money, the threat of cash limits for general practice, the new charges for dental and eye examinations, the proposed increase in the qualifying criteria for the full basic practice allowance, and the plan to increase to at least a half the proportion of a doctor's income represented by capitation fees. Speakers also criticised the emphasis on consumerism without mentioning patients' responsibilities and the fact that the emphasis on prevention implied extra work for general practitioners with little extra remuneration.

The day before the committee met the negotiators had seen the Minsiter for Health, Mr Tony Newton, to tell him of their initial reaction. While welcoming some of the proposals in the white paper, they had reminded the minister that the profession had been urging many of them on the department for several years.

There was some ambiguity, the chairman said, that £740m would be available as additional money. This was not the case and the minister had refused to confirm the amount likely to be available as it would "depend on the outcome of negotiations with the profession concerned." The minister had been quizzed on several proposals in the Health and Medicines Bill (summarised in the *BMJ* on 5 December 1987 (p 1499)). Mr Newton had deemed that the government intended that under clause 4 (the income generation clause) NHS patients would be charged for health authority services—for example, diagnostic services. Clause 5 will introduce a specific age of retirement for practitioners but the compensation to be paid in certain circumstances would apply only to dentists. There would still be 24 hour retirement under clause 6 but the pensions of doctors over 65 would be abated if they retired, drew their pensions, and returned to practice after 24 hours. This would not apply to those doctors who took 24 hour retirement before clause 6 came into force.

Clause 13 had perhaps caused the greatest concern, reported Dr Wilson. This would enable the Secretary of State to set annual cash limits for family practitioner committees and health boards, which would have a duty not to exceed them, for reimbursing certain expenses incurred by those providing family practitioner services. Questioned on this, the minister had confirmed that the intention was to limit expenditure on the improvement grant, cost rent, and ancillary staff schemes. Other items could, the chairman said, be included by regulation.

Although there was a long way to go, Dr Wilson believed that there was a prospect of making progress. Individual members of the House of Commons and the House of Lords would be briefed during the passage of the bill.

Shared anxieties

During the subsequent debate it was clear that many local medical committees shared the anxieties of Dr Wilson and the negotiators.

Several speakers, including Dr J A Rennie, said that there was too much emphasis on prevention. The government should educate people to take more responsibility for their own health; otherwise there would be insufficient time for basic general medical services. The proposal to increase the minimum list to qualify for the full basic practice allowance and to increase the average number of hours spent in surgery sessions would, she warned, discourage practices from taking on doctors with limited commitments. There were adequate arrangements for these doctors at present and she did not want assistantships to be encouraged.

Describing the white paper as an intelligent document, Dr David Williams said that it was a lesson in how to appear to give more money. It would raise the average workload required to reach average net remuneration for those with a full basic practice allowance. This would mean a reduction in remuneration for all doctors. Was there to be extra money for average net remuneration or was it just a redistribution exercise?

The government was in difficulties with the NHS and perhaps there was room for efficiency in primary care, Dr Williams suggested. If general practitioners were responsible for, say, 5% of the cost of prescribing would that make them more cost conscious in prescribing? In primary care the general practitioners were the managers and unless they were prepared to discuss economies they could lose the management function. The profession ought to go into negotiations with something to offer as well as something that it wanted.

Paragraph 3.9 (below) was fundamental to the whole of the white paper, according to Dr M Hamid Husain, and he believed that it would lead to general practitioners being required to work harder for the same income.

"(3.9) It is the government's intention therefore

At its meeting on 17 December the GMSC, under the chairmanship of Dr Michael Wilson, had its first opportunity to debate the white paper *Promoting Better Health*,[1] the Health and Medicines Bill,[2] the circular on community nursing and primary health care teams,[3] and the consultation document on district health authority access to family practitioner committee data.[4]

The main points of the government's proposals are:

New payments to general practitioners to encourage more preventive medicine and greater efficiency.

The abolition—with some exceptions—of free eye testing and dental check ups, with the expected extra annual income of £170 million promised for funding the planned improvements in primary care.

Hospitals will have new powers to raise money for their services.

Compulsory retirement at 70 for general practitioners, the abolition of "24 hour retirement," and the future distribution of family doctors to be more responsive to local medical and social needs.

Cash limits will be introduced on funds for direct reimbursement for ancillary staff and premises, but the ancillary staff scheme will be extended to a wider range of staff and greater allowance will be made in the cost rent scheme for regional variations in property costs.

The General Practice Finance Corporation will be privatised.

Incentives will be introduced to improve inner city practice.

Nurses may be given limited powers to prescribe for patients.

Pharmacists will be given financial incentives to widen their services.

This report was prepared by LINDA BEECHAM, assistant editor, *BMJ*.

to make the NHS contract with family doctors more sensitive to the range of services provided. This will be achieved over time by adjusting the balance between the doctor's income from capitation fees and the income from allowances. A basic core of health provision is expected for the payment of capitation fees which in turn will be complemented by incentive payments designed to encourage the provision of services targeted at specific health care objectives (for example, high levels of vaccination, immunisation and cervical cytology). At present capitation fees form on average 47% of the doctor's income. The government intends to raise this to at least 50% in the first instance. As public awareness increases and services improve, the government intends to move further in this direction in order to encourage doctors to practise in ways that meet patients' needs."

Among other points made by speakers were:

- The government seemed to think that competing for patients would lead to an improvement in care, whereas a smaller list size gave greater opportunity to improve care (Dr D G Eastham, Leeds).
- There was great emphasis on consumerism and patients' rights with no mention of their responsibilities; screening for screening's sake would occur and practices would need more full time partners just to screen the elderly (Dr P J P Holden, Matlock).
- It was no good screening people unless the doctor could take some action, and hospital services would have to be improved to take on all the extra people who would be referred (Dr C O Lister, Slough).
- The white paper would negate many of the hard won advantages of the 1966 family doctor charter and would mean less money for the same work or the same money for more work (Dr C H Zuckerman, Birmingham).
- The proposals to remove the restrictions on the staff that a doctor could employ through the direct reimbursement scheme and to improve the help available under the improvement grant and cost rent schemes conflicted with the clause on cash limiting in the bill (Dr A J Stanton, Wellingborough).
- General practitioners in East Birmingham Health District did not want a return to late surgery hours and were sceptical about having to produce annual reports (Dr Patricia Price, Castle Bromwich).
- Staff would not be available to man surgeries for longer hours and doctors would not have time to sit on the representative committees, so where would future local medical committees and GMSC members come from? (Dr M J Oldroyd, London).
- Kent and East Sussex Local Medical Committees wanted the negotiators to negotiate a package and bring it back to a special conference of local medical committees. Doctors in rural areas would find it difficult to reach a qualifying figure for a full basic practice allowance and a notional list scheme for sparsely populated areas would be needed (Dr J D J Farrow, Hawkhurst, Kent).
- "The white paper giveth and the bill taketh away"—The profession and the public had been mesmerised by the white paper (Dr J G Ball, Bewdley).
- In Scotland the average list size was 1600 and if there was to be a change in the criteria many practices would be disestablished (Dr M J Illingworth, Alva, Clackmannanshire).

The representative of the ophthalmic group committee, Dr M F P Marshall, said that the proposal to charge for eye examinations meant that general practitioners would have to consider their patients' financial position before referring them for an eye test. The proposal contradicted the government's aim to increase screening services as the financial barrier would be a deterrent. Dr Marshall forecast a reduction in the detection of eye disorders and an increase in the referrals to hospital outpatient departments, where the waiting time for non-urgent cases was often 12 months.

Dr J S Robson represents the General Dental Services Committee of the British Dental Association and he thanked doctors and local medical committees for their support in opposing the charges for initial dental examinations. The earliest that these charges could be introduced was October 1988, Mr Robson emphasised. The charges would be a severe disincentive and patients would be required to pay 75% of the cost of treatment up to a maximum of £150.

Dr P J Enoch urged the committee to take a positive approach and welcome the white paper for the opportunity it provided to move general practice forward after a decade of stagnation. Many of the proposals had originated from the GMSC—for example, registration fees, fees for paediatric surveillance, help for isolated practices, more support for practice premises, and fees for minor surgery. He hoped, too, that in responding the profession would speak with one voice.

Community nursing services

The circular on community nursing services and community health care teams instructs health authorities and family practitioner committees to discuss the organisation of community nursing services in their districts.[3] Local medical committees should participate in these discussions and the practice organisation subcommittee will prepare guidance for local medical committees on the circular.

Though the chairman had said that the proposals in the circular were very different from those in the Cumberlege report on neighbourhood nursing,[5] Dr S E Josse thought that it was a wishy washy document and a recipe for disaster. It did not give the profession what it wanted.

For his part, Dr R J Givans saw the circular as paying lip service to primary care teams and it would not preserve them. The chairman of the Welsh GMSC, Dr H I Humphreys, referred to the Welsh nursing review, which he said had come out in favour of primary health care teams, recommending that all districts should establish a community health unit.[6] The review might have influenced the English circular.

According to Dr J W Chisholm the proposals were as good as the profession was going to get, and he judged the principles set out in the circular to be reasonable. Neighbourhood nursing teams should be established only where it was practicable to establish a primary health care team, and the concept of nurse practitioners and nurse prescribing deserved further investigation.

Dr C O Lister conceded that there might be consultation but warned that the final decision would be made by the health authority. Emphasising this, Dr D G Eastham pointed to paragraph 9 of the circular as the crux: "It is for health authorities to determine the organisation and management structure of the community nursing services, and the deployment of specialist nursing staff in order to achieve the best service for people locally within available resources."

Clever rather than wishy washy was Dr Vincent Leach's description of the circular: the department had washed its hands of responsibility by allowing health authorities to take the decisions.

Dr J B Lynch, however, did not think that the GMSC would be very pleased if a circular about doctors had to be approved by the Royal College of Nursing before it was published. The profession had now been given an opportunity to provide some input, and he was sure that doctors could give some guidance on how the circular could be implemented properly.

Sharing FPC data

A working party has been set up to respond to the consultation document on district health authorities' access to family practitioner committees' patient registration data.[4] The members are Dr J W Chisholm, Dr P J Enoch, Dr J F Milligan, Dr Jane Richards, and Dr D M Wilks.

The committee was concerned that there should be a wide public debate as the proposals affected the rights of patients in determining who should have access to information about them. Dr P F Kielty and Dr P J Enoch drew attention to the statement in the white paper on the consultation document: "Subject to the outcome of consultation, an early opportunity will be sought to obtain parliamentary endorsement for a change in the present arrangements." The working party will draw the proposals to the attention of organisations that represent patients' interests.

Dr George Rae said that the responsibility of family practitioner committees might take second place to the interests of the health authorities and he recommended that the profession should make haste slowly.

Dr J W Chisholm reminded the committee of its policy. Data given for one purpose should not be used for another; if registration data were shared some people might be disadvantaged by a breach of confidentiality; the existing policy should be changed only after a full political debate. The profession was now being asked to come off the fence and the working party would need firm guidance.

According to Dr J F Milligan, the profession had wanted family practitioner committees to be independent so that health authorities should not dictate to general practitioners. Registration data should be held by family practitioner committees and used only for general medical services.

Dr D M Wilks favoured sharing information, but the profession should question the use to which the information would be put and ensure that it was not the first step to allowing clinical information to be divulged. The user code proposed in the consultation document was, he said, irrelevant under the Data Protection Act.

References

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